Quality Measures: Efficiency Tiger Team
Draft Transcript
October 8, 2010

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director
This is the Efficiency Tiger Team of the Quality Measures Workgroup. Let me do a quick roll call. Charles Kennedy?

Charles Kennedy – WellPoint – VP for Health IT
Yes, I'm here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Karen Kmetik? Robert Greene?

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Hello.

Judy Sparrow – Office of the National Coordinator – Executive Director
Kate Goodrich?

Kate Goodrich – ASPE – CMO
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Jon White?

Jon White – AHRQ/HHS – Director IT
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Niall Brennan?

Niall Brennan – CMS/HHS – Deputy Director
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Tom Tsang?

Tom Tsang – ONC
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Bob Kocher? Susan, I didn't get your last name, from Booz Allen.

Susan – Booz Allen
Yes.

Judy Sparrow – Office of the National Coordinator – Executive Director
Just remember since we're transcribing this call to identify yourselves when speaking. I'll turn it over to Tom.

Tom Tsang – ONC

Hi, everyone. Thanks for joining us again for the Efficiency Quality Workgroup Tiger Team. I just want to summarize our last administrative meeting and what we've done, and then I'll hand it over to Charles Kennedy. Last week we looked at the Gretzky Group report and the environmental scan and the report that we had contained some measured domains or measured concepts such as overuse of medications, overuse of procedures, and some examples of those sub-domains or measured concepts from the environmental scan from various organizations and entities.

However, the group felt that we needed to take a step back and paint a broader picture, so we reframed efficiency under five new sub-domains and they are, I'll go over them in order, the first one being a provider-centric efficiency measure and looking at whether the provider is delivering appropriate care based on the evidence and based on the guidelines. We actually named that as proven care, we borrowed the term from Geisinger. The second one is being person focused care that's coming from the patient or the person's perspective on whether they've received the appropriate care.

The third one is looking at population and public health. The fourth one would be leading conditions. There are very specific measures that exist right now such as the readmissions measurements for congestive heart failure, pneumonia, acute MI, that are actually being used in claims data and we should try to incorporate some of those measures that pertain to specific chronic diseases under this bucket. The last bucket is actually prevention and looking at appropriate care when looking at prevention.

So those are the five buckets. We received some responses from the Tiger Team members and at least for this meeting I hope we can actually come up with some priorities and some sub-domain measure concepts that we can walk away from after some meaningful discussion. I'm going to give the baton to Charles.

Charles Kennedy – WellPoint – VP for Health IT
Good morning or afternoon, as appropriate to everyone. What I'm going to try and do is meet Tom's objective of breaking down these five sub-domains—physician-centric, patient-centric, chronic disease, population and public health and prevention—and have a discussion in each one of these around what might make some sense as some potential measures around efficiency/resource utilization around each one of these areas.

There was an e-mail that was sent out shortly before the call that has a couple of Excel spreadsheets attached to it. You might want to open the combined measures for ONC efficiency, including overuse, under use file, as we begin to have this discussion.

Before I get started does anyone have any burning questions or any questions around the framework that they'd like to throw on the table?

Tom Tsang – ONC
I just want to point out to folks also as we debate and talk about these concepts there will be some methodologic challenges surrounding these measures. So for example, the readmissions measures have been based on claims data and not on information directly from the EHR so if we were to look at this in the context of EHRs how can we do this. So there will be a Tiger Team set up to look at these specific methodologic issues and that's going to be spearheaded by Jon White and the AHRQ folks and we can percolate these issues to that workgroup.

Charles Kennedy – WellPoint – VP for Health IT
That actually spurs a couple of questions from me. But I think someone else had a comment as well.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
First, since I'm new to the team I'd like to introduce myself very briefly—and then I had an overarching question for Dr. Kennedy—I just want to mention, first of all, thank you. It's an honor to be here. I'm in charge of the Clinical Analytics department at United and that involves clinical performance measurement and I report to Sam Ho, the Chief Medical Officer. That's my introduction.

Then in terms of overarching question: The EHR meaningful use can be applied to physicians or hospitals and some measures are best applied one to another, some might work best for a large group. Are all of those areas within our scope?

Charles Kennedy – WellPoint – VP for Health IT
I believe so, and Tom, you may want to jump in here as well. These frameworks were meant to give us a process to be able to go into, for instance, the physician-centric component or rather the patient-centric component might have transitions of care types of measures that might be appropriate either for physician-centric activities or hospital-centric activities.

Tom Tsang – ONC
Yes, everything that you've mentioned would be applicable in narrow context. As we think about these measures and as you look at the Excel spreadsheet that's collected, with measures collected from various organizations, we should be conscious that these measures, the goal is to create a set of measure concepts that we can translate into actual measures as we ask measure developers to think about these things that are HIT sensitive and HIT enabled, that are what we think are more parsimonious than the traditional measures that we've used in stage one. It would be great if we could use the same measures and be applied for both hospitals and eligible providers, but we understand the limitations and the different settings and so we may have to, if we have a limited set for one group we may need to do some further work.

Charles Kennedy – WellPoint – VP for Health IT
Tom, just a couple of other orientation comments: Our charge is really to focus on the development of measures as applicable, relevant and appropriate as we can in this particular workgroup. Our charge is not to worry about the necessary underlying infrastructure to deliver those measures. In other words, that other workgroup you talked about, that is going to be their accountability?

Tom Tsang – ONC
Yes.

Charles Kennedy – WellPoint – VP for Health IT
Just as a bit of an orientation, so this is more brainstorming—I guess measures, brainstorming almost, less infrastructure focused.

Tom Tsang – ONC
Right, okay.

Charles Kennedy – WellPoint – VP for Health IT
Any other questions before we get into the first sub-domain?

Jon White – AHRQ/HHS – Director IT
No other questions, but may I just take your comment a little bit further?

Charles Kennedy – WellPoint – VP for Health IT
Please.

Jon White – AHRQ/HHS – Director IT
Tom mentioned that we're going to have a methodology group that's going to stand up and try to address some of the methodological questions that come up. Ultimately, what all this feeds into are recommendations coming out of the Quality Measures Workgroup that go up to the policy committee. Tom's absolutely correct that we should be focusing on this without thought to is the infrastructure or capability there right now or not. Ultimately when it gets to the policy committee and it ultimately goes internal to get turned in to the next round of meaningful use regulations, those considerations do come into play. They may or may not be able to be adequately addressed by the methodologic workgroup; that was the only point I wanted to make. Thanks.

Charles Kennedy – WellPoint – VP for Health IT
Thanks, Jon.

Tom Tsang – ONC
To add on that, there will be a quality workgroup counterpart in the standards and interoperability HIT committee that will look at some of the technical issues of these measures.

Charles Kennedy – WellPoint – VP for Health IT
Let's begin to dive into a conversation about the physician-centric sub-domain, and maybe I'll just offer a couple of comments to kick off the conversation. The challenge that I have in the sub-domains is when I think of the creation of these measures the underlying process I think that we want to optimize is the patient care process, and of course for many of these measures that will span across multiple physicians. So when we look at things in the physician-centric box, my interpretation of that would be that we would be looking for measures that are most closely related to things that are directly under a particular physician's control. So things that come to my mind when we talk about this space would be a generic use rate.

Clearly choice of prescription is highly associated with a particular physician's decision making process and certainly has an efficiency component as well as a pretty substantial health IT component. Then as we move out from there, whether we look at radiology measures or others, I was wondering if that type of framework or that type of principle between the separation of what we'll call doctor-centric from patient-centric measures resonates with the group or if there are other opinions.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
What would be an example of a patient-centric measure that we'd be measuring off of EHR that would be a patient responsibility as opposed to a physician responsibility?

Charles Kennedy – WellPoint – VP for Health IT
This is good. I wasn't so much framing it in terms of perhaps responsibility or rather centeredness, so perhaps something like a readmission rate or measures associated with changes in transitions of care by definition involves more than one provider usually. So that might be something that might fall more in the patient-centric side of things than the physician-centric side of things, as an example. Does that work for people, or does that not create a good framework for the discussion?

Kate Goodrich – ASPE – CMO
I think it works. I just think that, as I think was alluded to, there are going to be some that appear to cross between the two buckets of patient and provider-centric. But otherwise it seems fine.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
I tend to think of things with a different slice, and it's not necessarily better but different. I think of the atoms as the things that happen to the patients, whether it's a readmission or getting an unnecessary back MRI. Then when you connect those patients you might connect them to a physician or physician group or an ACO system and then you get the system-ness in at that level.

Charles Kennedy – WellPoint – VP for Health IT
So you would look at the patients essentially as the building blocks or the, as you say, atoms, the foundation of the measures and then the physician-centric measures almost as roll ups of those individual experiences. Is that what you're saying?

Robert Greene – United Healthcare – Vice President for Clinical Analysis
Yes, and then you would roll them up as appropriate. So a readmission measure would work well for an ACO which has control of both ends, but might also work for a hospital which has a significant sphere of influence, if not total control, or a large physician group .... Then the framework that came in the other one like overuse of procedures, overuse of medication, avoidable readmissions, those become the domains for the patient, and that's, again, just a thought. I'd be interested in people's reactions.

Uh-oh, Tom, I've joined the group and I've stopped the conversation already.

Karen Kmetik – AMA – Director Clinical Performance Evaluation
Hi, everyone. It's Karen Kmetik. I'm sorry I'm late. I'm in a noisy area so I might start—

Charles Kennedy – WellPoint – VP for Health IT
Rob, could you repeat that comment for Karen?

Robert Greene – United Healthcare – Vice President for Clinical Analytics
First of all, hi, Karen, it's Rob Greene from United here. I'm a new member of the committee and I'm starting to make trouble already. The question came up in terms of the framework, and let me see if I can present both sides equally, see if I get it.

Should we look at physician centered measures which would be, for example, things under the scope of control physician ordering a generic medicine or not, versus patient centered measures which might be a patient is readmitted and therefore it cuts across multiple providers? My suggestion was I think of things as things that happen to patients and sometimes do you then roll them up to a physician, sometimes you might roll them up in multiple ways like to the discharging hospital and the physician group for readmission measure or an ACO for readmission measure. We were just beginning a discussion of that to ... framework.

Niall Brennan – CMS/HHS – Deputy Director
Are you saying that these distinctions are, meaningless isn't the right word, but maybe a little arbitrary, the patient and physician ... measures?

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Maybe. They're certainly not meaningless, I wouldn't be saying that. But I think you get a little more flexibility, in my experience, if you follow the patient and then you decide with the roll up logic what you're going to do with it.

Bob Kocher – McKinsey & Company – Associate Principal
This is Bob Kocher. Sorry for being a few minutes late.

Charles Kennedy – WellPoint – VP for Health IT
Thanks for joining. Then the roll up logic would essentially be your physician attribution methodology, or would it be something more than that?

Robert Greene – United Healthcare – Vice President for Clinical Analytics
It would be an attribution logic and you would have the logic for the purpose of measurements tracking.

Charles Kennedy – WellPoint – VP for Health IT
That makes sense. But that approach, I would say, could still be accommodated by this physician-centric and patient-centric kind of framework that we're having the discussion within, could it not, or is it incompatible?

Robert Greene – United Healthcare – Vice President for Clinical Analytics
I think in the patient-centric versus physician-centric there is potentially an inherent question of attribution and such, so it can be made compatible but I think that's one of the reasons I was suggesting they keep it patient centered and then separate out the issues.

Charles Kennedy – WellPoint – VP for Health IT
Well, given that perspective—and I think that makes a lot of sense—why not start with a discussion then perhaps around the patient-centric component and then we'll get into the roll up kind or the attribution kinds of issues when we start talking about the physician measures? So moving on to patient-centric measures, let me just open the floor around what comes to mind to this particular group around efficiency measures associated with what happens to the patient.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
I'll start; maybe I'll throw out one. One of the measures that comes to my mind is certainly readmission rates. A significant measure of both quality as well as efficiency, looking at transitions of care, perhaps slicing it by disease state, but at its most basic level calculating a readmission rate as an initial efficiency measure seems like something that might be relevant in looking at the efficiency of various practices.

M
Yes, I totally echo that, because to tackle it you also have to work on coordination and also use some predictive modeling to figure out how to do that well. So it has some virtues.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
UnitedHealthcare strongly supports a readmission rate. In fact, we've urged the CMS to use an all-cause readmission rate for all commissions.

Tom Tsang – ONC
Rob, when you talked about the roll up, are all of you considering someone would take this readmissions measure by itself and you then think about parsing out different aspects ..., such as there's a hospital perspective, there's perhaps a primary care perspective and then there's the patient experience perspective? Is that single measure concept, we can presumably have multiple—?

Niall Brennan – CMS/HHS – Deputy Director
Why are we trying to establish multiple perspectives? I hate to be overly simplistic, but why do we have to have patient-centric sub-domains and provider specific sub-domains when— I don't know. I just think it's all one big umbrella of efficiency and quite frankly I think just about any measure could be construed as being patient and provider specific. A patient doesn't want to go back into the hospital if—

Tom Tsang – ONC
I think you're absolutely right. This framework was somewhat arbitrary and I think we're taking a step back instead of when we went ahead with the sub-domains listed, it felt like, from the conversation we had, it felt like rifle shots into this broader framework of efficiency.

Niall Brennan – CMS/HHS – Deputy Director
I think I'm going to want to use that word, or maybe if I could contradict myself now, I think a generic versus brand type measure is actually a measure that doesn't impact the patient. It might impact them in the sense that their premiums will ultimately be a little higher if doctors keep prescribing brands instead of generics, but clinically speaking they're different—I guess they have a co-pay indication too, so it does affect them.

Charles Kennedy – WellPoint – VP for Health IT
Right, but I think, going along with the framework idea, that was when we would put it in a physician-centric category for all the reasons you just mentioned.

Tom Tsang – ONC
Niall, one possible patient-centric measure added to this readmissions measure would be the patient, like HHAPs and worrying about if patients are being discharged inappropriately from the emergency room and measuring this notion of stinting of care so one could conceivably think about serving the patient in the ER upon discharge, their care experience. I'm kind of just thinking out-of-the-box, such as when we have generic one measure readmissions which is based on claims data, they're looking at it from a systems approach, but then when you actually think about the granular details of the multiple pain points of this readmission you can actually parse it out into different representations of different care processes within the system.

Karen Kmetik – AMA – Director Clinical Performance Evaluation

I would just add given that part of our charge is to leverage the data in an EHR, then I think we'd want to think about what all could influence reducing the readmission rate by leveraging data in the EHR that we didn't have before.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Tom, all these things have partially answered the question you posed. Looking at it from different viewpoints in some ways gets us toward a root cause analysis. So if I were looking at readmissions from a hospital point of view we've developed a report, for example, which shows the most common readmissions and what they're connected to. That helps with the hospital root cause and things like patient experience of care, or the group receiving the discharge, they might have a different root cause, like it didn't get noticed that the patient was even in the hospital and things like that.

Charles Kennedy – WellPoint – VP for Health IT
I was wondering if people have comments regarding, we talk about all-cause readmission rates, but is that all-cause within a disease state or all-cause across all disease states more in an index type of approach?

Bob Kocher – McKinsey & Company – Associate Principal
I want to go back to Niall's point. I think it's critical actually that we be simple and not overly complicated in our framework or metrics. I would lean towards the all-cause because it would be a shame to have everybody focus on narrow areas and ignore the broader all-cause readmissions, since every study that I've read has shown that most readmissions can be avoided regardless of cause. So that would be my bias here. I'm also curious, practically, the NQF has a measure, number 329, all-cause readmission index, whether or not we think that's by itself appropriate or if it needs to be fixed or tweaked ....

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Hi, Mr. Kocher. I think you've met my boss, Sam Ho, along the way.

Bob Kocher – McKinsey & Company – Associate Principal
Yes, ...

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Very good. Let me state my conflict of interest that Sam and some of the folks who are now on my team developed that measure and we've used it with claims data, we have access projects using it in several ways. Now, in the commercial population, in the Medicare population of course the three disease specific ones represent a large number of the readmissions, but there's a lot of material in the other areas and I would agree with your comments for simplicity and parsimony and covering of the largest area that an all disease, all-cause readmission rate is a good thing.

Charles Kennedy – WellPoint – VP for Health IT
Does anyone want to make an argument for narrowing it, or are we settling on all-cause readmission rates, all diagnoses as one of our recommended threads? Hearing none and the proposal ... could we talk a little bit about is the NQF measure as stated, 329, acceptable given that it's claim base driven, or are there refinements to this measure we should consider that are more EMR data specific? Clearly, the CCD or a shared document which can be electronically sent offers the opportunity for greater care coordination and therefore I think the HIT sensitive piece being low, I might take a little bit of an argument there with that. But are there other things we should be considering around this measure to make it more EMR or HIT sensitive?

Niall Brennan – CMS/HHS – Deputy Director
Do we want these measures to be calculated virtually within an EMR or EHR? Or do we want to leverage the interoperability aspects where CMS or a private payer or even ideally a conglomeration of payers could calculate readmission rates from claims data and then shoot them to the EMRs and EHRs so doctors have them as they go about their daily business?

Charles Kennedy – WellPoint – VP for Health IT

I believe that it will be tough to make the EMR as a solo source or sole source work. So I think that we have to assume some level of aggregation and I think, Jon, if I'm interpreting Jon's comments earlier in the call correctly, that is going to be the accountability of somebody else to figure out the infrastructure necessary to make that aggregation or virtualization or whatever you want to call it real. Jon, is that right?

Jon White – AHRQ/HHS – Director IT
That's my understanding. Basically the purpose of the Tiger Team is to say what we think is the best measures that we ought to be pursuing going forward and then other folks are going to take it and say, okay, yes, we can do that if we do XYZ, or there's no way we can do that right now. Somebody needs to work on making that happen. Tom, you can confirm or deny.

Tom Tsang – ONC
That's correct.

Charles Kennedy – WellPoint – VP for Health IT
So I was thinking a claim based measure will certainly give you information around the raw readmission rate, but given the granularity of the data expected within an EMR are there ways we can refine that measure or in some way make it more HIT sensitive that anyone wants to suggest?

Niall Brennan – CMS/HHS – Deputy Director
Can you give me an example of making a measure more HIT sensitive?

Charles Kennedy – WellPoint – VP for Health IT
Perhaps, and again, this is just something off the cuff, perhaps the granularity of the data within the EMR might allow a better risk adjustment, might allow a better predictive model functionality that could in some way be applied to this measure. Just a little brainstorming here, but I guess the thing I would look at is, is the expected incremental electronic clinical data in some way usable or applicable to the NQF 329?

Niall Brennan – CMS/HHS – Deputy Director
One comment or question I have for the group is while I support the notion of an all-condition, all-cause readmission measure, what do people think, given that these tools are going to be pretty powerful, let's say if I'm a pediatrician and I'm looking at my EMR and I get a rate that's all-cause, all-condition, would there be a way to interactively stratify, and I deal mainly with pediatric ... patients, so that's really going to tell me about my practice, is there a way to say my all-cause, all-condition is 15%, but for my ... patients it's 22%? So it's not changing the underlying measure construction, it's just stratifying the end result. I don't know what Rob thinks of this because this is obviously a United measure and I don't know if they've thought about that.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
We have actually a readmission project going on with hospitals and a generator report that does that. So essentially I think this is an excellent idea and it's a reporting or drill down function.

Kate Goodrich – ASPE – CMO
I wonder if it might be helpful to review again Helen Burstin's definition of HIT sensitivity. Do you think that would be helpful? Because one of the things I often get confused about, and I don't know if others on the phone, if everybody's clear on this, sort of the notion that HIT sensitivity means that the use of an electronic record to collect the information for a measure reflects HIT sensitivity, when in fact it actually seems to mean something very different. So just looking at a document that Helen put together for us regarding HIT sensitivity, the way that she conceptualizes it or defines it is that HIT sensitivity means that with implementation of HIT functions such as clinical decision support, CPOE, etc., that that could result in improved outcomes or improvement in actual measure, so reduction in readmissions or whatever. So I just wanted to be sure that everybody is clear about that definition.

Tom Tsang – ONC
Thanks, Kate, for reminding the group.

Jon White – AHRQ/HHS – Director IT
Kate, since you brought it up, you may recall that I asked afterwards what's the level of evidence that's got to be associated with that—

Kate Goodrich – ASPE – CMO
That's right.

Jon White – AHRQ/HHS – Director IT
The consensus was, well, there may not be great evidence but if we can make a reasonable assumption that it might improve with some of the functionalities of HIT then we could deem it HIT sensitive. We might also introduce the concept of HIT enabled into our lexicon here, which is that it might be easier to get at some of the specific data for a measure from EHRs or other health IT systems as opposed to having to either approximate it from claims data or to try to manually slog it out of the chart.

Kate Goodrich – ASPE – CMO
I think that's helpful.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Even though conceivably these could all be done by claims by an aggregator, as CMS does for its measures now, would HIT enabled or sensitivity also count that these could be pushed back up? In other words, my patient got readmitted for asthma at a different hospital and I didn't even know it until the connectivity and the HIT told me.

Jon White – AHRQ/HHS – Director IT
As a family doctor, I would say absolutely. Yes, that's the kind of thing where if one of my patients showed up at the ER at the hospital across town and landed in there, I would want to know it.

M
I guess that was kind of a rhetorical question. Yes, me too. As a former primary care internist, yes.

M
I'm never hesitant to answer rhetorical questions that way.

Bob Kocher – McKinsey & Company – Associate Principal
I second that as a former primary care doctor.

Charles Kennedy – WellPoint – VP for Health IT
Tom, let me just check in with you. So it sounds like on this first measure we're settling on all-cause readmission rates, all-conditions with a drill down functionality and assumed virtualization or aggregation of the information reflective of multiple potential landing points, the hospitals, etc. Is that the type of output you're looking for? Is that sufficient for what you're looking for to get to the three themes for this sub-domain?

Tom Tsang – ONC
Yes, so 1 down and perhaps 15 more to go.

Charles Kennedy – WellPoint – VP for Health IT
Don't depress me. All right, let's move into the second category—

Tom Tsang – ONC
I want to point to the group that what you have in front of you are examples that are taken from the environmental scan. I would like to challenge the group to really think about aspirational measures on, if you don't see it here then we should go out and develop it. So don't be bound by what you see in front of you.

Robert Greene – United Healthcare – Vice President for Clinical Analytics

Would you like us to send suggestions offline? I have a number of lists of paper—

Tom Tsang – ONC
Let's see where we end up after this call and see where we have in terms of the buckets of measures.

Charles Kennedy – WellPoint – VP for Health IT
One thing before we leave the readmission rate point: Could we just spend a moment talking about risk adjustments and whether, given that it's all-cause, all-diagnosis, the role of risk adjustment in this particular measure?

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Sure, should I take that?

Charles Kennedy – WellPoint – VP for Health IT
Please.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Actually it can be used with either APR DRG or MS DRG. I think we run it both ways, but it's adjusted, your rate of readmission, your roll up facility, whatever, compared to the risk adjusted expected rate.

Niall Brennan – CMS/HHS – Deputy Director
I think the issue here may be that this could be an individual provider, an individual physician, let alone hospital roll ups. So there could be some sensitivity here regarding patient risk. I'm actually of the opinion that once you aggregate to hospital and even beyond, you need to worry less about that.

Charles Kennedy – WellPoint – VP for Health IT
Absolutely. In fact, in practical terms you need thousands of discharges to have enough readmissions to work with, so it probably works only for large groups, hospitals, and ACOs.

Niall Brennan – CMS/HHS – Deputy Director
Yes. I'm just thinking out loud too. Is it of any help—? Then again I have this picture of physicians walking around with iPads with data on them, so if that's wrong tell me. But is it any help to a physician to know that the underlying readmission rate for XYZ in their area is high, not necessarily for given patients.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
I doubt that that would be relevant. It's interesting, but I have a feeling if you're a provider ... that it would have little effect on your actual behavior or practice. ... instant helplessness ....

Charles Kennedy – WellPoint – VP for Health IT
So, Bob, you've got 100 people who are at the hospital during the year. I don't know if that's a number that's way too low or way too high, one year 8 of them are readmitted and the next year 12 of them are readmitted, are you a 50% worse doctor?

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Yes, I think if you're a doctor you would ignore that and think it's just random variation and you would try to blame it on the area and say, gee, I'm in a high readmission county.

Jon White – AHRQ/HHS – Director IT
Niall, that does become useful, not necessarily to Dr. Kocher or Dr. White, but that becomes useful to leaders of the community, leaders of the hospitals in the area that say, why do we have a higher readmission rate than folks around us?

M
..., yes.

Robert Greene – United Healthcare – Vice President for Clinical Analytics

That's exactly how we've used it. The hospitals then go out to their physicians, and you're absolutely right, Niall, each physician might have five or ten but the overall hospital programs are the population level and that helps a lot.

Niall Brennan – CMS/HHS – Deputy Director
We're thinking about this off the ... context as opposed to an individual physician context or maybe a large medical group practice context.

Charles Kennedy – WellPoint – VP for Health IT
Correct. Large medical group, ACO, and the hospital, that's where I think of—

Niall Brennan – CMS/HHS – Deputy Director
Okay, great. Thank you.

M
Hence, Tom, my initial question about which levels we're working at, which I think fits with that formulation.

Charles Kennedy – WellPoint – VP for Health IT
Okay, one down. Let's move on, so perhaps next week we could move into the area of emergency department visits and the sub-categorization of those types of visits. We have various types of measures. Some specifically look at an overall ED visit rate. They can be parsed as ambulatory sensitive ED visit conditions, so let's open a conversation now about how should we think about either preventable ED visits or ambulatory care sensitive ED visits and what things come to people's minds around that issue.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
I'll try not to be too shy on my first call, and I apologize if I'm jumping in too much, but a couple of things there. In our patient centered medical home pilots we're looking at the ambulatory sensitive conditions, and that's the AHRQ definitions. We have done previously some projects on a smaller set which are the non-emergent emergency room visits that would be something that could be useful at a physician and practice level as a reflection of poor access to the practice. The other measure which we are using and working with hospitals on is the ER to admission, or ER to either inpatient or observation unit. It's a slightly different flavor, it's kind of the next step, but we find that there's a lot of variation among hospitals in escalating the emergency room visit into an inpatient or an observation stay.

Charles Kennedy – WellPoint – VP for Health IT
Rob, can you talk a little bit about how you break that measure down? Do you look at it on a condition specific basis? How do you break it down further?

Robert Greene – United Healthcare – Vice President for Clinical Analytics
We use AHRQ chapters for case mix adjustment, so it's not fully risk adjusted but we do see a huge variation on that, hospitals with tens of thousands of emergency room visits who are 30%, 50% above state averages, even just adjusted for the case mix.

Kate Goodrich – ASPE – CMO
Are you looking at patients admitted to an actual observation unit, so I'm thinking in my head something like an MI rule out unit, or are you looking at patients who are admitted to "observation?"

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Neither. It's really a measure of patients not sent home from the emergency room.

Kate Goodrich – ASPE – CMO
I see, okay.

Charles Kennedy – WellPoint – VP for Health IT

Other comments on ED visit measures? Relating this measure to the previous measure, do you see this measure as, again, from an overall system efficiency perspective as valuable, less valuable, or more valuable than the all-cause readmission?

Bob Kocher – McKinsey & Company – Associate Principal
I think it's complementary, so I think the 72-hour return visit measure is a potentially useful one, and I'm also a proponent of some sort of ... considerations of a metric like time to antibiotics for pneumonia, or doing an intervention for a stroke type measures potentially too.

Charles Kennedy – WellPoint – VP for Health IT
Now, are those more quality or do you see those as efficiency—? I guess it measures the efficiency of how the ED is operating.

Bob Kocher – McKinsey & Company – Associate Principal
Yes, they're both right. So you have to have efficient, well designed processes to actually execute these and the timing ... productive. So productivity, it just so happens that it's completely aligned with quality. We can do capacity utilization and have a similar productivity measure, but far less compelling I think to focus on that as opposed to efficiency that delivers value to patients.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Charles or Tom, in United's experience the emergency room escalation is a much larger resource and cost center because it's much more common than readmission. It's probably almost an order of magnitude, depending on the hospital.

Tom Tsang – ONC
Rob, when you do that analysis, do you take into account, such as available ERs within that geographic area? Is there some sort of adjustment process for access and other factors that may determine utilization?

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Let's see, you're thinking about people coming to the emergency room because it's the only one there or people once they're in the emergency room being admitted. I think the admission and observation rate, I'm not sure if that's related to access.

Charles Kennedy – WellPoint – VP for Health IT
Could you say more on that? If I was interpreting Tom's statement, Tom, are you getting at the notion of how effectively were they treated in the emergency department perhaps resulting in a discharge to home versus hospitalization as some kind of interventional measure? Or were you getting at something else?

Tom Tsang – ONC
I'm just looking at it from the standpoint of if there aren't enough providers in the geographic area for follow up care, then they may be sitting in the ED for greater than 72 hours before discharge, or if there aren't enough beds in the hospital for admissions, so all these other secondary reasons for why they're still in the observation unit or they're returning within 72 hours because of follow up.

Charles Kennedy – WellPoint – VP for Health IT
I'm sorry, so that was directed to Mr. Kocher then.

Bob Kocher – McKinsey & Company – Associate Principal
Can you repeat the essence of the question? I apologize.

Tom Tsang – ONC
Bob, I'm just thinking out loud about this measure returning to ED within 72 hours or looking at the very specific issues like time to receive thrombolytics. I'm just wondering like the issue of access and whether that comes into play in the analysis.

Bob Kocher – McKinsey & Company – Associate Principal
I don't think it does. This is something that perhaps further development and maybe public comment would elicit, but if you used ... time for a cath then you might have a problem because it's not ... or antibiotic ... then there's ... can't do that. The same for during a stroke, so I don't think that there's an access problem per se and strictly ... in the ER that you arrive at, you should have ... protocol. For antibiotics obviously the ER can deliver that. So I suspect it's okay, but everyone on the call might have firsthand experience of complications that I'm not aware of. I know these are in fairly wide ... use among commercial plans, so some of our commercial plan folks can comment on their experience with these.

Charles Kennedy – WellPoint – VP for Health IT
Great, so just to summarize where the conversation seems to be, I think what I've heard is we see the ED visit measure with large as both complementary to the readmission rate measure as well as, as important or potentially more important given the huge variation in rates, the dollars associated with the measure, etc. What I didn't quite get clarity on is how we feel about the specificity of the measure, preventable versus return rate versus ambulatory sensitive. Was there a particular preference for the group in any of those three different slices of the measure?

Niall Brennan – CMS/HHS – Deputy Director
I apologize. I have to get off the call now.

Bob Kocher – McKinsey & Company – Associate Principal
Niall, in your closing comments do you have a preference among those methodologies?

Niall Brennan – CMS/HHS – Deputy Director
Which ones, Bob, sorry?

Bob Kocher – McKinsey & Company – Associate Principal
Ambulatory sensitive condition, all-cause readmission or revisits, or— What was the third one?

Charles Kennedy – WellPoint – VP for Health IT
Ambulatory sensitive, return rate, or preventable.

Niall Brennan – CMS/HHS – Deputy Director
I have a slight bias towards ambulatory sensitive only because they're the ones that I'm most familiar with. They're NQF endorsed, if that matters, and they're public domain. Whereas, I think potentially preventable may be proprietary.

Charles Kennedy – WellPoint – VP for Health IT
Great, thank you.

Niall Brennan – CMS/HHS – Deputy Director
Thanks, and I look forward to seeing the meeting notes. I'm happy to contribute via e-mail next week.

Tom Tsang – ONC
Thank you.

Charles Kennedy – WellPoint – VP for Health IT
Any other comments on the preference of these three types of ED visit rate measures?

Robert Greene – United Healthcare – Vice President for Clinical Analytics
The ambulatory sensitive certainly would pick up a larger number than just the non-emergent. To acknowledge Niall's comment, both the non-emergent which would be based off a set of diagnoses and also our ER to inpatient, they're not yet NQF endorsed but they might come into the category of things for further investigation.

Charles Kennedy – WellPoint – VP for Health IT

Moving on to the next area: Are there things within electronic medical records or the expected electronic medical record health IT infrastructure that in some way could make this measure more powerful, more relevant, more actionable? Any thoughts in that area?

Bob Kocher – McKinsey & Company – Associate Principal
... of course, but I'm not sure it's necessary to have the measure ... responses that one would want. It would be great to tie in things like ... co-morbid conditions, whether or not they have any kind of encounters ... with providers after they left an ER, ... actual course of .... All these things would be nice modifiers to help improve the efficiency and equality. But I suspect that none of them are going to need it and create a fair amount of value ....

Charles Kennedy – WellPoint – VP for Health IT
Just summarizing what you said, I would think again this notion of drill down maybe being able to understand how many of these, let's say, I don't know visits that resulted in a return was there no primary care physician visit in the interim, and perhaps having that information right at the physician's fingertips might cause an intervention, either a call to the doctor or a notification to the doctor or some counseling of the patient. So I could see how that could create some incremental value.

Bob Kocher – McKinsey & Company – Associate Principal
Sorry to jump in on this right away again, but I guess I wouldn't want us to make an impediment to an option of these that you have to have EHR add-ins to make them useful. I think they definitely are better with EHR supplements but I would hate to have that be a reason why we would delay recommendations towards these measures.

Tom Tsang – ONC
I would second Bob's comment. As we move forward with the discussion I think we should, if this group feels like these specific measures are great, then I think we can vet them through the measure developers and see what can be done and what can't be done.

Charles Kennedy – WellPoint – VP for Health IT
Part of the charge here was to "brainstorm" so I'm trying to carve out something formal in the discussion where we talk about specific EMR enablers or enhancements. I wasn't intending to make it in any way appear something that would retard or slow deployment of these measures. So that's the underlying intent.

Bob Kocher – McKinsey & Company – Associate Principal
I'm sorry, I think I'm having post-government stress disorder, so that was where that conservatism comes from. I do think all these measures become remarkably richer when they're supplemented with EHR data, because we all know from claims that you can't ... what was ... you can't really do a risk adjustment and attribution as well as you'd hoped. You'd really like to know something about the clinical condition of the patients on each of these episodes ... the initial ER visit and then the unplanned follow up one. I think there's a huge value from augmenting the EHR data, so I didn't mean to be negative on it. I was more saying there's no huge value without it, but clearly these are more powerful, more impactful, and ... productivity when we add in EHR.

Charles Kennedy – WellPoint – VP for Health IT
Very good.

Bob Kocher – McKinsey & Company – Associate Principal
I'm normally the one saying we should do the impossible.

Charles Kennedy – WellPoint – VP for Health IT
No worries. Okay, let's move on from ED visits and take a look at another area. This one perhaps we could take a look at the notion of diagnostic testing and this will get into an appropriateness area, but the appropriateness of the use of various diagnostic interventions. There's a fair number listed on your spreadsheet starting with, I think it's row 14. Let me just launch the discussion around unwarranted

diagnostic tests, scale of the value of measures in that area similar to readmission rates in ED visits, less what do people think of it as a concept?

Bob Kocher – McKinsey & Company – Associate Principal
Sorry, I'm passionate about this one because these are all easy to access in terms of improving behavior and performance right away. Speaking of near term value for this, there's really excellent arguments for patient safety and quality and efficiency, and these ... measures are precisely part of the prayer and hope ... ideas that were once ... to identify where we put overuses and then get it out. This set is pretty targeted ... with the ... and so I'd love us to be aggressive in tackling this area.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
I absolutely would second those comments. It's probably the third cost area after hospital bed days and admissions and such, and clearly with the recent press about CT scan radiation exposure, not only the mistakes and accidental overexposure, but the general overexposure I think is a key patient safety issue as well.

Tom Tsang – ONC
Good, so we have safety value and efficiency value, we even have some passion around this measure, which I love, let's drill in a bit around the specifics of the measure, maybe starting in the area of radiology. I guess maybe the first question would be, we could do measures that just look at redundant tests, tests repeated within a certain period of time that perhaps would not be repeated if HIT and data sharing was enabled. We can look at appropriateness types of tests, but maybe just starting out with the notion of ... redundancy. What thoughts do people have around that as an efficiency measure and how might we get at it?

Charles Kennedy – WellPoint – VP for Health IT
Maybe I'll start while people are thinking. We've looked at some measures in this area associated with CT scans from a couple of different vendors and our own analysis, where we looked at, I think it was CT scans repeated within 30 or maybe it was 45 days of the original scan, same level of clinical knowledge, meaning, let's say a CT scan with followed by a CT scan without would be considered duplicative. But a CT scan without followed by a CT scan with would not be duplicative because you're picking up incremental clinical knowledge there.

We've seen tremendous variation in the rates of these types of repeat studies. The underlying assumption was the studies were done with entities that had different tax IDs, with the underlying assumption being there is no data sharing going on in these particular regions, therefore, Dr. A probably did not know what Dr. B had already ordered. We did find tremendous variation sometimes in many of the smaller cities, maybe 1% to 2% of all studies, but in places like New York and some of the other larger metropolitan areas with tremendous numbers of specialists we actually saw 5%, 6%, 7% improvement of all studies falling within this category. So with that as a background I think this is perhaps an order of magnitude smaller than the first two areas we talked about, but still given the safety points it seems like a meaningful measure to include.

Tom Tsang – ONC
When you look at those studies do you take into account whether the providers have a radiology diagnostic—?

Charles Kennedy – WellPoint – VP for Health IT
... modality in their office?

Tom Tsang – ONC
Yes, a benefit management system in place that would go through some sort of decision support that would look at whether this test is necessary and so on and so forth.

Charles Kennedy – WellPoint – VP for Health IT

We did not assume that a decision support tool was in place in the classic nature of decision support. We did assume that our radiology management program, which for many of these studies requires a pre-auth, so we would take into account was a pre-auth required and if so the assumption was that that physician would have been notified that a claim had been submitted for the same type of study, claim lag and other things are an issue, but we did assume that that pre-auth function was there and at least provided some level of notification of someone else doing the same or very similar studies.

Tom Tsang – ONC
Okay, so then I would also then ask the larger group when we're specifically talking about reduce costs of redundant testing and looking at overuse, are we drilling down to specific leading conditions, or would this be an all-cause type of measure? So, for example, are we looking at something like lower back pain or cough or would this be applicable to all types of diagnostic tests and all types of conditions or symptomatology?

Robert Greene – United Healthcare – Vice President for Clinical Analytics
I like the direction this is going very much, and in line with cross-cutting and parsimonious, I would be interested in seeing a measure, I think there would be points in a measure of overall CT scan usage. I was at a lecture about a year ago—a private lecture from a fellow who's done research and I'm blanking on his name. He's a radiologist in New Hampshire. He pointed out that lifetime exposure to 10 CT scans between the neck and the pelvis is equivalent to the radiation levels from Hiroshima that started increasing cancer. So the HIT aspect is that you could push up into the system the places that are doing the CT scans, and then simultaneously you could push down or back in an order entry or clinical decision support, hey, do you know this patient has already accumulated 12 CT scans for their kidney stones and their lung nodule and such?

M
Remind me to make all my CTs head CTs.

Tom Tsang – ONC
This is definitely cross-cutting, because then you can actually get this measure extended to patient safety then.

M
Actually—

Charles Kennedy – WellPoint – VP for Health IT
Another thing I like about this measure is we tried to do what was suggested in our radiology management subsidiary, where we tracked cumulative exposure to radiation based on claim data and pre-auth data, and one of the problems he ran into was that depending on the CT scan that was deployed there were actually meaningful differences in the amount of radiation that was used by the machine in creating the image. I don't know if that's still true, but certainly some of the older machines you had much more exposure than the younger machines. Assuming that health IT enables us to tie into the tax system we might be able to get some additional information around that and make that calculation more accurate and more valuable.

Tom Tsang – ONC
I'm going to push the group, just trying to be sensitive to time, to articulate this concept for a note taker, or can someone summarize for us what the actual measure concept would be?

Charles Kennedy – WellPoint – VP for Health IT
Okay, so take this as a stake in the sand. The measure would be a measure of I guess use rates of imaging modalities such as CT scans where a study was repeated within a short time period, I won't define the time period, but within a time period and the information – what am I trying to say? I guess it's just really repeat the radiology exam within a short time period for the same—

M

... indication.

Charles Kennedy – WellPoint – VP for Health IT
... study.

M
And then ... exposure.

M
I think two separate exams.

Bob Kocher – McKinsey & Company – Associate Principal
... two cumulative radiation exposures, even better if it can be machine specific. Then I think ... bucket of redundant testing, which, and I'm not sure if ... definition for that. In redundant measure testing it was the Gretzky one that they used, it's a three month period where they do repeat testing for the same indication and they have a list of the tests that they ... in scope for redundancy.

I also like the idea, Charles and team, you guys should be up on this one ... but do you think that perhaps some of the more narrow imaging ones too about whether or not you're doing it for a CT scan for headaches, for mild traumatic brain injury, for the ... for atraumatic headache, and ... measures that are overuse measures, very tactical, ... high value too. Most of ... outpatient setting, like outpatient doctor office encounter, but I suspect these might also have added value.

Charles Kennedy – WellPoint – VP for Health IT
I would agree. I think under the overuse measures we have some sub buckets here. One is redundant testing that I was struggling to define; another is cumulative exposure; then a third one, I think you're pointing to is appropriateness. So the appropriateness ones would be more disease specific or condition specific than the previous two. Is that the sense of the group?

Robert Greene – United Healthcare – Vice President for Clinical Analytics
They're complementary, I think. There are, as someone was pointing out, the tactical aspects, specific things, those by definition will have narrower scope and smaller effects and then there are the broader measures like redundancy and cumulative exposure.

Jon White – AHRQ/HHS – Director IT
Is Karen Kmetik still on by chance? I know that she was in a louder place so she was keeping her phone muted, but I just don't know, are you still on, Karen?

Tom Tsang – ONC
Karen is actually on the plane flying right now. She just e-mailed me. So she'll look at our notes and contribute off line.

Jon White – AHRQ/HHS – Director IT
Okay. I value all the input that's being given here and I would really like to hear what PCTI would offer on this concept.

Charles Kennedy – WellPoint – VP for Health IT
Okay, very good. Let's then leave the area of radiology and overuse measures. Just looking at the time, does anyone have a suggestion around which type of measure that they'd like to take a look at next? We could look at drugs, antibiotic appropriateness. I'm open to suggestions in the spirit of time. Or let me ask it this way, is there another measurement area that we think would trump the three that we've identified so far, or at least are similar in importance?

Robert Greene – United Healthcare – Vice President for Clinical Analytics
As I was looking at this list or related list, the topic of inappropriate site of service or unnecessarily intense site of service as a broad category occurred to me. We've touched on that with a discussion of

emergency room, and there's a couple of other aspects to that. One is surgeries that are done as an inpatient when they can be done as an outpatient, and another touches on our readmission discussion, which would be adjusted length of stay. So I propose that as a potential area and that would be a pretty big one.

Charles Kennedy – WellPoint – VP for Health IT
Great, thank you, Rob. So regarding site of service, I could see a pretty straightforward and simple measure, but I would assume if we're going to do anything there more than just an aggregate bulk measure we're going to get very rapidly into questions around the patient context and the patient condition. Is that important? In other words, will we have to have more patient contextual information to make that measure relevant and meaningful, or is it acceptable just to have an overall rate?

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Let me start with the last one I mentioned, the adjusted length of stay. That's the one that at United we have paired with the readmission rate, and they balance themselves out. So the length of stay is also a safety issue because of the cumulative risk of adverse events, and when we talk to hospitals about that they say well, our patients will feel like we're pushing them out too early. Our counter is, yes, that's why we paired this with a readmission rate, so those two kind of go together. If you put them out too early and have too many readmissions that's no good, but if you decrease length of stay by decreasing unnecessary days you're benefiting everybody. That's also an NQF approved measure. I think that might be 328, that's right behind the readmission rate.

The inpatient versus ASC I think would require more evaluation. But there's huge, huge cost differences and we've looked at specific procedures like cholecystectomy, obviously sometimes they have to be inpatient, we've looked at that as an outpatient hospital versus ASC costs, multiple two, three times the cost, so there's opportunities on the appropriate site of service there, and that might have to be more granular. But
for common operations it can be quite significant. Then we've talked about the emergency room and escalation, kind of in the same topic.

Charles Kennedy – WellPoint – VP for Health IT
Great. Thank you, Rob. I'm figuring that perhaps the adjusted length of stay is an enhancement to the readmission discussion.

Bob Kocher – McKinsey & Company – Associate Principal
I think that's a no-brainer. I've been thinking about it, though. I love the notion about appropriate set of care and I've been trying to figure out how, as we've been talking, how do you patient contextualize that. That's clearly the one that we might say falls under the list of needs development work, because with EHR you ought to patient contextualize that and come up with an index. You can imagine a basket of procedures that we know are generally ... cost settings and then integrate that against a patient's ... factors to figure out whether somebody's a ... or something. But obviously I'm describing what ... but it's a really important concept. I encourage us to capture it as an area of ... for future work. Maybe you have good work already. I'm not aware of it, though.

Charles Kennedy – WellPoint – VP for Health IT
Okay, very good. So we'll add the site of service outpatient versus, excuse me, ASC versus inpatient as kind of a fourth area to explore, and we will amend the readmit rate to have a line in there about consider or recommend pairing with just average length of stay. All right—

M
Good.

Charles Kennedy – WellPoint – VP for Health IT
... Tom, I think that gives you the first sub-domain. Is that sufficient? Can we move on to the second?

Tom Tsang – ONC

Yes.

Charles Kennedy – WellPoint – VP for Health IT
So the second sub-domain we will try to move into, and again, this is perhaps an artificial framework so apologies for that, are measures we can link more specifically perhaps to the physician, physician decision making, perhaps more at the point of care, and maybe here we can take on the issue of prescribing patterns.

So within this bucket a couple of things immediately come to mind. One is, of course, the generic utilization rate. But why don't we open the discussion up around other aspects of prescribing appropriateness such as use of first line antibiotics, ATC appropriate use guidelines for pacemakers and defibrillators, and for catheterization. Were those all of them?

M
I was focusing on drugs for now, but yes, that would be another category, absolutely, within the group, absolutely.

Bob Kocher – McKinsey & Company – Associate Principal
For drugs I would add antihypertensives following ... guidelines and using appropriate antihypertensives.

Charles Kennedy – WellPoint – VP for Health IT
Antihypertensives, antibiotic appropriateness.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
This is an area where the added EHR information would be really, really important. So very simple outcomes measures like blood pressure, so for example I can tell you with very good detail what separates the high cost physicians from low cost on hypertensive care, and a lot of times it's just prescribing pattern, but until you know the outcomes for blood pressure control, then you can't construct an economic frontier analysis or such. So you can save somebody using the appropriate medicines and you can save a lot with better outcomes if you connect it to blood pressure.

Charles Kennedy – WellPoint – VP for Health IT
Any other comments on prescribing patterns? What about do we want to specifically link it to ePrescribing? Do we want to create a measure around not just drug-drug interactions, but perhaps the physician's reaction to the presentation of drug-drug interactions? In other words, for maybe top tier drug-drug interactions do we track a rate of whether the physician responded to it?

M
That's a really interesting idea.

Charles Kennedy – WellPoint – VP for Health IT
I'll just relay some of the experiences we've had, because we've tracked that in several ePrescribing pilots that we've done. What was interesting about the measure was the variation in it, and when you went out and talked to the physicians what you found was that it all depended on the workflow or a lot of it depended on the workflow of how the tool was implemented. Physicians who tended to still operate in a paper-based environment but used, let's say, a standalone ePrescribing utility because we were offering a bonus or whatever the purpose and they had a staffer using it, actually had, as you would guess, very low rates of reacting to the drug-drug interaction alert, whereas, physicians who had really embedded it into their practice and were the actual direct users tended to have a higher reaction to the drug-drug interaction, although even then there were some who pretty much blew through the vast majority of the alerts and others who reacted to the alerts quite commonly.

Bob Kocher – McKinsey & Company – Associate Principal
I apologize. I've got to jump off. My speech is about to start here at ..., so keep ... and be creative. I'll catch up with you all soon.

Tom Tsang – ONC
Thank you, Bob.

Charles Kennedy – WellPoint – VP for Health IT
Thank you, Bob.

Tom Tsang – ONC
Charles, can I take the conversation back just one step and ask you guys, in the measures that are looking at inappropriate treatment such as antibiotics for URI, what exactly are—? I'm not familiar with the measure or NQF number 69, but are you basing it on what the specific ICD-9 code at the end of the visit and then looking at whether an antibiotic was used or not. How does the measure actually work?

Robert Greene – United Healthcare – Vice President for Clinical Analytics
I can help with that. That is for pediatrics only and it looks for office visits with a specific diagnosis 465.9, and there's a little bit of a look back and look forward and then that diagnosis is viral URI and by definition does not need antibiotics. So any antibiotic prescription found is considered to fail the rule. They have some exclusion logic for people concurrently on antibiotics for other conditions.

Tom Tsang – ONC
I see, okay.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Number 58 works the same way, except it's adults with specific diagnoses of non-bacterial lung diseases, so chest colds.

Tom Tsang – ONC
So presumably then, as you said before, Rob, the additional clinical information that's embedded in the EHR could overwhelmingly help make these measures a lot more sensitive and specific since it's not just looking at ICD-9 codes but you can actually look for the physical findings embedded in the record, or you can look at keywords in the chief complaint or something.

Charles Kennedy – WellPoint – VP for Health IT
Yes, it might be the other way around. So right now if you diagnose it with sinusitis instead of viral URI, the measure doesn't ..., and sinusitis, depending on what you read, is only 2% to 20% bacterial, so you could construct something that said your EHR does not support even if this was sinusitis using antibiotics. Or conversely you could create some sort of case mix of ... adjusted overall antibiotics for minor respiratory conditions measure.

Jon White – AHRQ/HHS – Director IT
I do want to point out that you're starting to get close to the area of saying not did you appropriately or inappropriately use antibiotics for your diagnosis, but did you make the right diagnosis to begin with? Did you pick up the right things ... chief complaint, did you pick up the right things on physical exam or whatever test that you've done, and we're starting to get to a slightly different sort of appropriateness or inappropriateness kind of thing, right?

Tom Tsang – ONC
Yes, you're right, Jon. That's why I was wondering exactly what the logic model is for that measure or for these types of measures.

M
At least the first two are well established NQF measures and they're part of health plan ... as well.

Tom Tsang – ONC
But I assume they were endorsed based on the claims and administrative data. Is that correct?

M

Correct, that's right.

Charles Kennedy – WellPoint – VP for Health IT
So in the retooling process there may be additional information that can be added in the logic model.

M
Yes.

Charles Kennedy – WellPoint – VP for Health IT
So let's see, so just wrapping up on pharmaceuticals we have specific areas we want to look at, antihypertensive, antibiotic appropriateness, we have general areas we want to look at, specifically generic use rates, formulary adherence rates, and safety alert reactions. That would be an efficiency measure because presumably you're avoiding some number of adverse drug-drug events which some percentage of those will result in a hospitalization. These are measures which will be improved through the use of EHRs because we'll get biometrics, which will be important specifically as antihypertensives, as an example. Anything else on the area of pharmaceuticals that we should be considering?

M
Charles, there's a specific NQF measure which I've always liked, which is the 602. It's adults with frequent acute migraine medicines that also receive prophylactic medicines. I suffer from migraines a fair amount, so I'm familiar with this and have seen this among my patients, so that's kind of good because it's underuse of not only simple medications but also other factors that prevent migraines and overuse of the $25 migraine pills.

Charles Kennedy – WellPoint – VP for Health IT
I'm sorry, you said this is NQF which one?

M
602.

Tom Tsang – ONC
Can I ask you guys, any medication overuse in the area of cardiac conditions, measures related to Warfarin ...? Are you aware of any measures looking into that?

Charles Kennedy – WellPoint – VP for Health IT
I've always been focused on underuse or appropriateness of use. Overuse—

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Some of that you'll pick up with the generic versus brand, so there's clearly overuse of ARBs as opposed to ACE Inhibitors. ARBs are all brand and they're heavily promoted. But I agree with the last speaker, in general addressing underuse is good, but increases costs. But underuse of beta blockers after MI, underuse of ACE Inhibitor or beta blocker for heart failure actually probably prevents admissions. So those are the ....

Tom Tsang – ONC
Those are excellent points. Thank you.

Charles Kennedy – WellPoint – VP for Health IT
The only other efficiency measure, do we want to think about some kind of structural measure in here like do you have interoperability prescribing, just including that as more of a structural measure. Or ePrescribing with decision support, I guess that's more a former meaningful use measure. I think while in stage one it's requiring 40% and so I think that requirement will most likely increase.

M
Right, in stage two, yes.

Jon White – AHRQ/HHS – Director IT
You'll have to forgive my ignorance here. Does ePrescribing in stage one require formulary support? In other words, does it have formulary drugs built into the ePrescribing function?

M
I don't know if it gets to that level of specificity.

Jon White – AHRQ/HHS – Director IT
Okay. Here's why I'm going to throw this out. One of the only studies that I know about, because it happens to have been done by us, that shows that health IT can actually save money, is that when you ePrescribe with formulary built in as compared to ePrescribing without formulary and prescribing by paper you can save $8 per member per year on drug costs, which is not huge but it's not insignificant either. So to the extent that you push ePrescribing as a structural measure I would strongly encourage that formulary support be built in there.

Charles Kennedy – WellPoint – VP for Health IT
Yes, we had generic use rates and formulary adherence rates, so I absolutely agree.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
I just have a structural question about the Medicare drug benefit. I agree with everything that we're trying to do here, and it's extremely important from lots of good points of view, but is Medicare set up so that if there are savings on pharmacy it gets back to Medicare? As I recall, it gets back to the Part D PBMs. Do you know what I mean?

Charles Kennedy – WellPoint – VP for Health IT
Yes. In other words, if you promote formulary adherence or generics or whatever, do the savings actually accrue to the federal government or is it captured by the PBM?

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Correct. I was down at CMS talking about hypertension prescribing problems, and the staffers then, this was probably four or five years ago, were shaking their heads and saying oh well, it doesn't help us because any of the savings just go to the PBMs—

Charles Kennedy – WellPoint – VP for Health IT
I think you're right. Rob, I think you're right, because they establish a price for the Part D services, right? Yes, I think you're right.

Robert Greene – United Healthcare – Vice President for Clinical Analytics
Unfortunately in the Medicare world that may be something that has to get changed and otherwise just becomes a lower priority for practical reasons. It's still important to do, frustratingly enough.

Charles Kennedy – WellPoint – VP for Health IT
Yes. Tom, I apologize, but I need to get off the call as well a few minutes before the next call I'm on to get some documents together. Do you want to carry on or how do you want to proceed?

Tom Tsang – ONC
Sure. Let me just do a time check because we need to leave five to ten minutes for the public to comment. I'm wondering, a lot of people have jumped off, so we have two options. Since Bob and Niall and Karen are off the call right now, we can continue, but then it would be Rob speaking with Jon.

Jon White – AHRQ/HHS – Director IT
Look, buddy, I'm in it to win it but ... a one-sided conversation.

Tom Tsang – ONC

So another option would be to stop here and then we can work off the notes and then add a fourth call if needed. We don't have a fourth call to schedule right now, but we can coordinate and find time for a one to two hour call after the next call. The next call is on the 13th, so what do folks think?

Robert Greene – United Healthcare – Vice President for Clinical Analytics
I would agree with Jon and it would be lovely to talk with you, Jon, and others, but I think having multiple voices on the committee is important for process and reasonable.

Tom Tsang – ONC
Charles, can I recommend to the group that we end here and leave five minutes for public comment, and then we will continue next week?

Charles Kennedy – WellPoint – VP for Health IT
Very good.

Judy Sparrow – Office of the National Coordinator – Executive Director
Operator, please let us know if there are any public comments.

Tom Tsang – ONC
Okay, I don't think we have any public comments at this point. Our next meeting is on the 13th and we will send out an agenda with the phone number. Susan from BA and I will coordinate in terms of the meeting notes and send a revised Excel spreadsheet. Thank you so much for everyone's input and time. Thank you, Charles, for your leadership on this call.

Charles Kennedy – WellPoint – VP for Health IT
Thank you.

Tom Sang – ONC
Have a good weekend, everyone. Bye.